DHMC In-patient Falls Prevention Program

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Timeline of our project

- August 2004 –given charge to form separate multidisciplinary committee (RN, LNA, MD, Pharmacy, Risk Management, Safety office, Engineering, Purchasing, Data management, Housekeeping)
- September 2004 –attended “Patient Fall Protection” conference at WRJ VA (NH/VT Federal Safety and Health Council)

Timeline

- Oct-Dec 2004 Reviewed falls risk assessment tools, evidence based literature – made decision to stay with DHMC “homegrown” tool
- Dec 2004-Jan 2005 –performed Health Failure Mode and Effect Analysis (HFMEA) to determine areas of needed change

DHMC Fall Risk Scoring method

History of falls	2
First 24 hours post op	1
Anesthesia / substance use	2
Diuretics, laxatives, sedatives, Tranquilizers	1
Confused, disoriented, or unable to make purposeful decisions	3
Uses assistive devices, unsteady gait or unable to ambulate	3
Impaired hearing, vision or tactile sensation	1
Age > 70	1

Total Points=

Score: if > 3, RN must initiate appropriate falls prevention activities
Even if score $\leq$ 3, admitting diagnosis may indicate patient is at risk

Timeline

JCAHO National Patient Safety Goals for Hospitals Reduce the risk of patient harm resulting from falls:

- 2005
  - Assess & re-assess patient's risk to fall
  - Include risk associated with patient's medication regimen
  - Take action to address identified risks
- 2006
  - Implement a falls reduction program

Timeline

March 2005 – Attended NH Falls Risk Reduction Task Force Conference "Evidence Based Falls Risk Reduction in the Elderly: Taking it back to your community and making it work"(8 committee members attended)

April 2005 –multiple presentations to DHMC staff stakeholder groups about falls project, pilot site selected →one 10 bed pod of neuroscience unit (high rate of falls)

Timeline

April 2005 AIM statement -The process of reducing falls starts at admission to MHMH and ends with discharge. On the DHMC inpatient units, we aim to:

- Decrease the patient fall rate by 50% in 2 years
- Decrease the incidence of significant injuries from falls by 50% in 2 years
- Decrease the incidence of repeat falls by 30 % in 2 years

We will start with a pilot project on the DHMC inpatient Neuroscience and Neuroscience Special Care Units (5West and NSCU). The process starts with admission to these units and ends with discharge/transfer from these units. We aim to:

- Decrease patient fall rate by 30% in 6 months and 50% in 1 year.
- Maintain the low injury rate from falls.
- Decrease the incidence of repeat falls by 30 % in 1 year.

Timeline

- May 2005 –3 members attended national Falls Conference in Florida (Univ. of Southern Florida and James A Haley Veteran's Hospital) "Evidence-based strategies for patient falls and wandering"
- June 2005 started pilot program
  - Designed stamp of daily re-assessment, documentation of interventions
  - Quick debriefing of involved staff after a fall, and consult to rehab and pharmacist
  - Multiple environmental changes requested
  - "At risk to fall" bracelet chosen to ID pts, double sided non-slip slippers selected

Documentation stamp for daily re-assessments

AT RISK TO FALL TODAY Y N (Use Admission Assessment Fall Risk Scoring Tool method to re-assess) If Yes, complete interventions below

PLAN: **Environmental Modifications** Signage
Reduce Clutter Nightlight

Cognitive Deficit: Bed alarm Exit alarm

Time void: Q2h (day) Q4h (night)

Diversional activity At nurse's station when up in chair

Review of meds

Instruct pt. to call nurse when getting OOB

OTHER: _____

Impaired Mobility: TABS Bed alarm Assistive device: _____

Shoes when up / non skid slippers PT OT

Timeline

July-August 2005

- struggled to get environmental room changes
- selected/designed a uniform “At risk to fall”magnetic sign for metal pt doors, but discovered problem with attachment
- Found nice poster from Cleveland Clinic for pt rooms – permission given to adapt for DHMC use.
- Use of stamp from Pilot unit expanded to two other units
- Request made to Auxiliary for more equipment (gait belts, grab bars, walkers, alarms).

Timeline

July 2005 – Definition of falls (From VA toolkit)

- **Fall**: sudden, uncontrolled, unintentional, downward displacement to the ground or other object.
- **Near fall**: sudden loss of balance that does not result in a fall
- **Unwitnessed fall**: when action of the fall is not observed

Timeline

September – October 2005

- JCAHO visit
  - staff ed for all in preparation
  - cited Pedi and OB units for lack of assessment,re-assessments
- Ordered signs (funds from NH HHS)
  - for pt doors – “at risk to fall”
  - for rooms –pt/family ed
  - for bathrooms –”call, don’t fall”

Sign for patient rooms

No Fall Zone

FALLS CAN LEAD TO SERIOUS INJURY
IN HOSPITAL PATIENTS

Always remember to:

- Sit a few minutes before standing
- Call for assistance if weak,lightheaded, or dizzy
- Wait for help to arrive
- Use the toilet regularly to prevent hurrying to the bathroom
- Turn on the lights at night before getting out of bed
- Keep IV tubing and cords off of the floor when walking
- Ask someone to help unplug your IV pump
- Wear non-skid slippers or socks

Call…

Don’t Fall!

Sign for patient bathrooms

Call…

Don’t

Fall!

Timeline

November 2005 - January 2006

- Reviewed literature on pedi patients and fall risk assessment tools – not much there
- DHMC clinical experts designed tool for Pedi, adapted from our adult tool – implemented January
- Implemented assessment/reassessments in OB January
- Revised Falls policy, approved by DHMC policy committee January 18, 2006

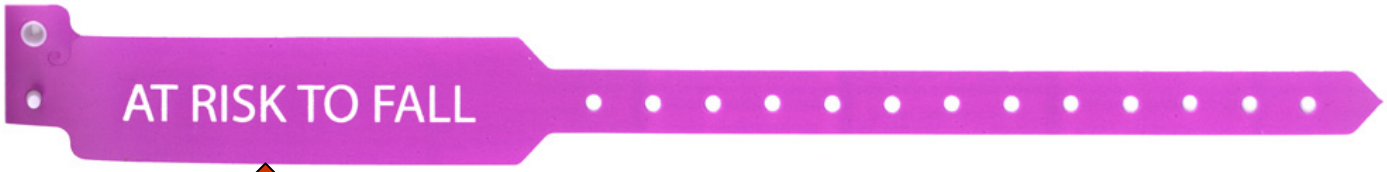
Timeline

February 2006

- •presented training (powerpoint poster, policy) on new system of re-assessments, signage, bracelet etc to educators for all nursing units

March-April 2006

- •implemented revised falls prevention system and inservice throughout DHMC nursing units



At risk to fall bracelet for patients at **High Risk to Fall**.
"Please wear this to allow us to know to give you extra help"

At Risk to Fall sign for patient's room door for those at **High Risk to Fall.**

Allows all staff and visitors to know to help patient

Timeline

April 2006 –

- MD on our team e-mailed all MDs about new signage system and their responsibility to assist with preventing pt falls
- Presented “train the trainer” powerpoint education to all Department directors – separate training for non-nursing staff emphasizing their role

Lessons learned

1. Use what is already out there (VA toolkit http://www.va.gov/ncps/SafetyTopics/fallstoolkit/index.html , Hartford Institute for Geriatric Nursing http://www.hartfordign.org/)
2. Check out the evidence. Many areas (falls risk tools, certain interventions)don't show much efficacy, or not in your setting.
3. What you have already may be fine, especially if staff already know how to use it (home grown assessment tool)

Lessons learned

4. Think about your setting. Some things translate well from community-LTC-acute care, some don't.
5. Involve all interested parties (departments)in your team
6. Don't get discouraged, keep trying. Timing is important (EG use concerns re JCAHO to get rapid changes made!)